VIRGINIA DEPARTMENT OF HEALTH

Office of Family Health Services – Division of Women's and Infants' Health

Perinatal Guidelines and Resources

July 2004

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Table of Contents

Acknowledgments p. 3

Introduction p. 4

Section 1
Office of Family Health Services p. 6

Section 2
Clinical Standards p. 8
- Preconception Health Care p. 8
- Prenatal Care p. 8
- Postpartum Care p. 15
- Reference List p. 17

Section 3
Administrative Policies and Guidelines p. 19
- Policy Guidance – Delegation of Nursing Tasks to Unlicensed Personnel p. 20
- Documentation by Exception (DBE) p. 24
- Required Notification to Minors Choosing "Do Not Contact" Status p. 24
- Workplace Safety p. 27
- Case Management p. 28
- Eligibility and Sliding Scale p. 30
- Department of Medical Assistance Services (DMAS) p. 31
- Clinical Laboratory Improvement Act (CLIA) p. 31
- Institutional Review Board (IRB) p. 32

Section 4
Division Resources and Programs p. 33
- Family Planning p. 34
- Sterilization p. 34
- Pap Smear Screening p. 34
- Regional Perinatal Councils p. 34
- Virginia Sickle Cell Awareness Program p. 35
- Resource Mothers p. 35
- BabyCare p. 36
- Virginia Healthy Start Initiative p. 36
- Bright Futures p. 36
- Breast and Cervical Cancer Early Detection Program p. 37

Section 5
Child and Adolescent Health p. 39
- Child Development Clinics p. 39
- Pediatric Screening and Genetic Services (PSGS) p. 39
  - Virginia Genetics Program p. 40

Virginia Newborn Hearing Screening **p. 43**

Section 6

Women, Infants, and Children and Community Nutrition Services (WIC) **p. 45**

Section 7

Center for Injury & Violence Prevention **p. 48**

Section 8

Other State or Local Resources and Programs **p. 51**
Virginia Chlamydia Prevention Program **p. 52**
Virginia Perinatal Hepatitis B Prevention Program **p. 52**
Healthy Families **p. 52**
Comprehensive Health Investment Project (CHIP of VA) **p. 53**
Department of Mental Health, Mental Retardation and Substance Abuse Services (Community Service Boards) **p. 53**

Table 1: Prenatal Laboratory Evaluations **p. 56**

Appendices

A. Virginia Department of Health Standards of Care
B. Prenatal Nutrition and Breastfeeding
C. Perinatal Substance Abuse: Virginia Screening Requirements
D. Perinatal Depression
E. Rh D Hemolytic Disease
F. Sexually Transmitted Diseases
G. Cervical Pathology Algorithms
H. Human Immunodeficiency Virus (HIV)
I. Hemoglobinopathy Screening and Follow-Up
J. Gestational Diabetes
K. Cystic Fibrosis
L. Preterm Labor and Birth
M. Adult Immunization
N. Regional Perinatal Council Contact List

Acknowledgments

Updating these guidelines did take several years, during which many people met as a committee to share their knowledge. The Division of Women's and Infants Health Director and Perinatal Nurse Consultant launched this process by identifying people to come together as a committee to update the "Maternal Child Health Guidelines" to become the Perinatal Guidelines and Resources. The members of the committee made enormous contributions of time and expertise.

Perinatal Guidelines Committee:
Judy Eckard, Mecklenburg County Health Department, Boydton, VA
Barbara Jackson, Piedmont Health District, Farmville, VA
Vicki Stamps, Chesterfield Health Department, Chesterfield, VA
Marcia Alberston, Chesterfield Health Department, Chesterfield, VA
Debbie Martin, Henrico Health District, Richmond, VA
Debbie Townsend, Petersburg Health Department, Petersburg, VA
Paige Cecil, Chesterfield Health Department, Chesterfield, VA
Bonnie Darrel, Fauquier County Health Department, Warrenton, VA
Debbie Bowers, Case Health Center, Alexandria, VA
Theresa Golub, VDH-Maternal Death Review Nurse
Joan Corder-Mabe, VDH-Division of Women's and Infants' Health, Richmond, VA
Theresa Taylor, VDH-Division of Women's and Infants' Health, Richmond, VA

Reviewers:
David Suttle, VDH – Director of Office of Family Health Services
Karen Connelly, VDH – Director of Public Health Nursing
Perinatal Guidelines Committee Members
Michele Andrews, BSN, CNM, MPH - Consultant

Introduction

The Perinatal Guidelines and Resources of the Virginia Department of Health were developed as a guide for local health department personnel in the development and management of ambulatory perinatal health services. It is also intended to serve as a resource for orienting new staff to these health services.

The following guidelines and resources are not all inclusive, and may need adaptation to best address the needs of a specific area or population. Each component should be viewed as part of a continuum of care and should be considered in the development of any program. Continued flexibility to meet specific needs and to perform within available and accessible local resources is important and emphasized.

The goal of prenatal care is to ensure an optimal pregnancy outcome by the provision of quality antepartum care and follow-up for mother and infant. The guidelines indicate minimum services for acceptable health supervision. Clinical practice and management are influenced by a variety of factors. However, decisions regarding management of clients receiving prenatal care through the Virginia Department of Health in general should be based on guidelines set out by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, Guidelines for Perinatal Care, 5th Edition. More specific policies and procedures can be developed as district or local needs and patterns of practice dictate.

All pregnant women in Virginia benefit from services of the Virginia Department of Health. Health department services for pregnant women, mothers, and infants are provided through a network of health district offices and local health departments. Quality, cost-effective prenatal health services are provided by a network of physicians, nurse practitioners, and nurses working under the supervision of the district medical director or a contracted board-certified obstetrician. Charges for services are based on a sliding-fee scale adjusted according to family size and income. Priority for many services is given to low-income women, teens and infants and to geographic areas with limited medical resources.

Quality comprehensive maternity care also requires services provided by other agencies. Examples of such services may include special education and mentoring for pregnant teens, substance abuse treatment, mental health counseling and treatment, and the many services provided by community-based agencies.

Use of the guidelines and resources by other agencies or private practitioners is welcomed. The hope is that they serve as a framework for the development and implementation of responsive and quality perinatal care.

SECTION 1
Office of Family Health Services

The Virginia Department of Health's Office of Family Health Services (OFHS) consists of 50 programs, which are under five divisions and one center.

- Women's and Infants' Health
- Child and Adolescent Health
- WIC and Community Nutrition Services
- Dental Health
- Chronic Disease Prevention
- Center for Injury & Violence Prevention

The mission of the OFHS is to provide the leadership, expertise and resources that enable all of Virginia's residents to reach and maintain an optimal level of health and well being. Program managers work closely with other areas of VDH, such as the Office of the Chief Medical Examiner, the Office of Health Policy, and the Office of Epidemiology. Information has been obtained from all of these areas and correlated together for the making of the **Division of Women's and Infants' Health**, Perinatal Guidelines and Resources.

SECTION 2

Clinical Standards

- Preconception
- Prenatal
    - History/Assessment and Risk Assessment
    - Physical Exam
    - Documentation
    - Laboratory Studies
    - Follow Up and Teaching Interventions
- Postpartum

Clinical Standards

Preconception Health Care

Ideally, prenatal care begins prior to conception. All health encounters during a woman's reproductive years, particularly those that are a part of preconception care, should include counseling on appropriate behavior to optimize pregnancy outcomes. Counseling and assessment should include medical/surgical, including immunization status, obstetrical, genetic, gynecological, and family histories should be taken. Preconception health care within the health department setting generally occurs within the department's Family Planning clinics.

Folic acid, taken before pregnancy and for the first three months of pregnancy, can reduce the risk of neural tube defects. The U.S. Public Health Service suggests that all women (even if they are not trying to conceive) consume 0.4 mg of folic acid a day. Although folic acid is found in foods such as leafy dark-green vegetables, citrus fruits, and beans, it is difficult to consume enough of them to meet the daily requirement. Therefore, a daily folic acid supplement or multivitamin is suggested.

Women who have had a previous pregnancy where a neural tube defect was present in the fetus, have a higher than average risk of the problem recurring. These women should take 4 mg of folic acid daily—10 times the amount normally recommended—for 1 month before conception and during the first 3 months of pregnancy. The folic acid should be taken separately and a regular multivitamin that does not contain folic acid should be utilized to avoid overdosing on folic acid. Folic acid at this level is a medication prescribed by a physician or nurse practitioner.

Prenatal Care

Comprehensive Health History and Risk Assessment

Every woman should have a comprehensive program of antepartum care that begins as early as possible. Early diagnosis of pregnancy and on-going risk assessment is important in establishing a management plan appropriate to the individual client. Documentation of prenatal services in the Virginia Department of Health is accomplished using the documentation by exception record system. (See Appendix A VDH Standards of Care) The Virginia Department of Health in 1999 adopted documentation by exception as the preferred method of documentation. Local Medical Directors have the ultimate decision as to which Prenatal Record is used in their respective health district. For details related to the specific utilization of the documentation by exception model, which includes the Standards of Care, DBE forms and documentation instructions, refer to the Documentation by Exception Record System Manual. This manual can be downloaded at http://www.vdh/nursing/except.htm.

Every woman seeking perinatal services at a health department clinic should be provided with basic prenatal services. These services reflect minimum expectations. The actual content of care, beyond these minimum standards, must be governed by appropriate

clinical practice and based on specific needs of the client. In situations where local health departments do not provide direct prenatal care services, arrangements should be made with local physicians, a local hospital or a nearby health clinic to provide such services.

Prenatal care consists of health promotion, risk assessment, and intervention linked to the risks and conditions uncovered. The prenatal period begins with conception and continues until labor begins.

Prenatal care providers are health professionals who offer primary, secondary, and tertiary care for pregnant women, including support for their families. Prenatal care providers include obstetricians, certified nurse midwives, family physicians, nurse practitioners, physician assistants, and community health nurses. Despite the fact that several specialized providers may be involved in one woman's care, one prenatal care provider shall have responsibility for her care and assure coordinated, comprehensive, quality services. Specialized health care professionals and others are those who offer specific services in support of prenatal care. Examples of this group include consulting physicians, social workers, nutritionists, psychologists, health educators, and community health workers such as Resource Mothers.

Prenatal visits are in-person contacts between the pregnant women and a prenatal care provider. The visits usually take place in the practice setting of the care provider, but may take place in the woman's home, at school, in the hospital, or at other sites.

For the purposes of data collection for the Virginia Department of Health, prenatal care is defined as a prenatal visit with a prenatal care provider who conducts health assessment including assessment of physical and psychosocial risks, performs clinical and laboratory tests, and establishes and/or implements the plan of care.

ACOG recommends that women with normal pregnancies should be seen by a health care provider once in the first trimester, monthly until 28 weeks, when care should be scheduled every two weeks, and weekly starting at 36 weeks of gestation. Ideally, women experiencing a normal pregnancy should have between 12-14 prenatal care visits. More frequent visits may be indicated based upon the clinician’s judgment.

Signs and Symptoms of Pregnancy

If a women expects pregnancy, most health departments will provide pregnancy testing. The signs and symptoms that may be reported by the woman are usually categorized by presumptive, which frequently are reported but not conclusive of pregnancy; probable, which are more reliable indicators of pregnancy and can be noted upon physical exam or laboratory testing; or positive, when absolute confirmation of pregnancy is made. Many clinics require a positive pregnancy test before a prenatal care visit is scheduled. The exception is the woman who is well into her pregnancy and pregnancy is confirmed by presence of fetal heart beats or fetal movements.

Provider standards of care for maternity patients have been established in association with the Document by Exception record. The standards represent the core components of

care that shall be provided to achieve optimal outcomes. Adherence to these standards is required regardless of actual record system used for documentation.

At the first prenatal visit a health record should be established on every patient, if not previously established prior to conception. The health record should include a comprehensive general medical history of the client, family history, a psychosocial risk assessment and a genetics assessment. In addition, health departments provide services that include:

- Pregnancy evaluation
- Case management
- Specialized testing
- Nutrition assessment and intervention
- Patient education relative to health maintenance, preparation for childbirth and parenting

Client History: The first step in the assessment of the prenatal patient is the medical history. Taking and documenting the medical history is recommended for all pregnant women at the first prenatal visit. Those items to be assessed are the following:

- Sociodemographic data: age, race/ethnicity, education level
- Menstrual history: age at onset, regular or irregular, LMP
- Past obstetrical history: uterine or cervical abnormalities, history of two or more miscarriages, fetal deaths, infant with birth defect, or born less than five and a half pounds weight.
- Contraceptive history: method used, satisfaction with method, last time used
- Sexual history: difficulty with intercourse, problems with conception, high-risk behaviors
- Medical/surgical history: any surgeries, diagnosed chronic diseases, prescription drugs
- Infection history: diagnosis of STDs, history of blood transfusions or other bodily secretions, HIV status (see Appendix H)
- Family and genetic history counseling
- Nutrition: vegetarian, eat unusual substances, such as laundry starch or clay, history of bulimia or anorexia, any special diet, uses any diet supplements or vitamins (See Appendix B for Prenatal Nutrition information)
- Immunization history: record status with routine vaccinations. (Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pnemococcal, Polio, Rubella, Tetanus/Diptheria, Varicella, see Appendix M) “No evidence exists of the risk from vaccinating pregnant women with the inactivated virus or bacterial vaccines or toxiod”. (MMWR 2-8-02) Healthy women who will be in their second and third trimesters of pregnancy during the influenza season should consider receiving the routine influenza vaccination. Pregnant women at risk for the Hepatitis B virus should be offered the Hepatitis B Vaccine. (MMWR 2-8-02)

Genetic History and Counseling

At the time of the first prenatal visit, routine inquiries should be made about both the mother and the father of the baby. Assessment areas should include:

- Family history of congenital abnormalities, mental retardation, and known inherited metabolic disorders
- Previous child with Downs Syndrome or other chromosomal abnormalities
- Previous stillborn
- Known hemoglobinopathies
- Two or more spontaneous abortions
- Maternal age over 35
- Family history or previous pregnancy with a neural tube defect such as spina bifida, meningomyelocele, anencephaly
- Family history of close relative with mental retardation
- Any history of chromosomal studies
- Jewish heritage in either parent
- Screening for Sickle Cell Disease
- Screening for Cystic Fibrosis

When the risk of a genetic or other birth defect is identified, an accurate, specific diagnosis or etiology is necessary to define the prognosis and to establish the risk of occurrence or recurrence. Careful, sensitive counseling should be provided to the client, the father of the baby, and her family. When possible, the client should be referred to the regional genetics center for further testing and counseling. (see Section 5, Virginia Genetics Program)

Genetic Screening in Various Ethnic Groups

Ethnic Group	Disorder	Screening Test	Definitive Test
Ashkenazi Jews	Tay-Sachs disease	Decreased serum hexosamidase-A, possibly molecular analysis	Chorionic villus sampling (CVS) or amniocentesis for enzymatic assay or molecular analysis to detect affected fetus
	Canavans disease	DNA analysis to detect most common alleles	CVS or amniocentesis for molecular analysis to detect affected fetus
African-Americans	Sickle cell anemia	Presence of sickle cell hemoglobin, confirmatory hemoglobin electrophoresis	CVS or amniocentesis for genotype determination (direct molecular analysis)

Ethnic Group	Disorder	Screening Test	Definitive Test
Mediterranean people	B-Thalassemia	Mean corpuscular volume (MCV) < 80%, followed by hemoglobin electrophoresis	CVS or amniocentesis for genotype determination (direct molecular analysis or linkage analysis)
Southeast Asians and Chinese (Vietnamese, Laotian, Cambodian, Filipino)	a-Thalassemia	MCV < 80%, followed by hemoglobin electrophoresis	CVS or amniocentesis for genotype determination; (direct molecular studies) (direct linkage analysis)
All ethnic groups	Cystic fibrosis	DNA analysis of specified panel of 25 CFTR mutations (those present in ≥ 0.1% of the general U.S. population)	CVS or amniocentesis for genotype determination; definitive diagnosis on all fetuses is not possible; sensitivity varying by ethnic group
	In Caucasians and Ashkenazi Jews should be offered; in other ethnic groups (Asians, Hispanics, African-Americans) should be made available		

Psychosocial Assessment

A basic psychosocial assessment is an integral component of comprehensive prenatal care. Psychosocial screening of all patients presenting for prenatal evaluation or prenatal care is an important step toward improving women's health and birth outcomes. Because problems may arise during the pregnancy that were not present at the initial visit, it is best to perform psychosocial screening once each trimester to increase the likelihood of identifying important issues and reducing poor birth outcomes. (ACOG Compendium, 2003)

Basic components of a psychosocial history may include:

* family composition and function, other social support
* adjustment to pregnancy, perceptions, attitude
* existing support systems
* presence or history of abuse, physical or emotional
* substance use, type, frequency, last used, including smoking, alcohol, and illicit drugs (See Appendix C for Virginia screening requirement.)
* cultural issues affecting pregnancy, health care
* mental health status, current or past diagnosis, depression, suicidal attempts/ideation (See Appendix D on Prenatal Depression.)
* environmental need and resources – housing, financial, employment, transportation, child care, work environment

Due to the sensitive nature of subjects assessed, a private location should be utilized for the interview.

Assessment of Teaching Needs
Education of the prenatal client should be based upon an assessment of the clients needs and be individualized to her level of understanding, prioritized to address her immediate interests. Education should occur throughout the pregnancy based upon the periodicity schedule as outlined in Appendix A.

Physical Examination
The physical examination is a comprehensive physical exam by a clinician which in VDH could be a physician or nurse practitioner. See Appendix A for a copy of the Standards of Care: Normal Pregnant Female Exam from the VDH Documentation by Exception.

Laboratory Tests
There are several laboratory tests that should be performed routinely in pregnant women. Many of them are done initially to screen for various conditions and then other tests are ordered periodically throughout the pregnancy based upon national standards or client factors. The following are the minimum laboratory tests recommended by ACOG. (See Table 1.)

- Hemoatocrit or hemoglobin levels (see Appendix E: Rh D Hemolytic Disease)
- Urinalysis, including microscopic examination
- Urine testing to detect asymptomatic bacteriuria
- Determination of blood group and CDE (Rh) type
- Antibody screen for Rh negative women
- Determination of immunity to rubella virus (Clients without the adequate immunity should receive vaccination furing the immediate postpartum period.)
- Syphilis screen (see Appendix F for STD information)
- Cervical cytology (as needed) (see Appendix G for Cervical Pathology algorithms)

- Hepatitis B virus surface antigen
- Human immunodeficiency virus antibody testing (see Appendix H)
- Sickle Cell (see Appendix I)
- Gestational Diabetes (see Appendix J)
- Cystic Fibrosis (see Appendix K)

All prenatal clients should be screened for gestational diabetes (GDM) either through assessment of high-risk factors, patient history, or laboratory screening using the 1-hour post 50 g glucola plasma screen 24-28 weeks gestation. This test may be waived in very low-risk groups such as a teen without other risk factors. (See Appendix E.)

Women with gestational diabetes may be asymptomatic throughout pregnancy or have only subtle signs. Therefore, earlier testing (prior to the 26 to 28 weeks' gestation) of symptomatic women will facilitate prompt intervention. Identification of these high-risk for gestational diabetic women should consider both historical factors and/or findings in the current pregnancy.

Subsequent Prenatal Care Assessments

At each subsequent prenatal visit, measurement of the client's weight and blood pressure, assessment for fetal movement, fetal heart tones, evaluation of the client's urine for blood, protein, ketones, nitrites and glucose; and determination of fundal height must occur and be recorded. The clinician is responsible for assessing other items that may indicate high-risk or complications of pregnancy (see Appendix A for Maternity Visit Record) which includes but is not limited to items such as nausea and vomiting, backache, vaginal discharge, fetal position, uterine cramps or bleeding. The visit is an excellent time for the client and/or her family to ask questions and discuss concerns and should be encouraged by all members of the health care team.

Weeks 12-16

See the laboratory periodicity table for required or indicated laboratory tests to be performed. (see Table 1)

Weeks 16-20

Fetal movements (quickening) should occur between the 18^{th} – 20^{th} week of gestation. It is helpful if the client's report of fetal movement is recorded.

Weeks 24-28

Again, see the periodicity table for required or indicated laboratory tests. Signs and symptoms of premature labor should be assessed. (see Appendix L on Preterm Labor)

Weeks 28-32

If not already decided, arrangements for newborn and pediatric care should be discussed. Arrangements or counseling information will vary dependent upon the health district.

Weeks 34-36
Again, see the periodicity for required or indicated tests. Plans for delivery such as a transportation plan and arrangements with the birth hospital should be completed. The copying and sending of client records to the birth facility will vary depending upon the health district protocols.

Weeks 36-40
Any education regarding infant feeding, postpartum family planning, or availability of infant car seat should be completed. Any formal preparation for childbirth classes should also be completed.

Weeks 40 and beyond
The clinician will devise a plan for postdate delivery. Counseling as to any fetal surveillance should be provided.

Postpartum Evaluation

Postpartum review and examination should be accomplished 4-8 weeks after delivery. Earlier evaluations may be done in the home or clinic setting depending on client need. The first postpartum review should include the following:

I. Delivery Data
1. Date and place of delivery
2. Length of gestation
3. Type of delivery
4. Sex and birthweight of the baby
5. Apgar score
6. Complications
7. Medications
8. Infant feeding method (see Appendix B on Breastfeeding)
9. Place of birth (hospital or home)

II. History
The client's labor and delivery experience should be reviewed. The interview should also include questions relating to physical, emotional, or psychological problems encountered during the postpartum period. Assessment should be made regarding the following:

- Adjustment to parenting - attitudes, perceptions of need for care
- Coping abilities of client and family; support system (see Appendix D)
- Sexual relations
- Contraception
- Determination of need for immunizations (including rubella) if not done immediately postpartum
- Exercise
- Infant care (see Child Health Section)
- Maternal plans for continued well child care

- Other learning needs as appropriate

III. Physical Examination by clinician should include the following:
- Weight
- Blood pressure
- Breasts
- Abdomen
- External and internal genitalia
- Lochia/vaginal discharge

Newborn Assessment: Refer to the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, Second Edition.

Neonatal Hearing Assessment

A history or presence of one or more of the following identifies the newborn at risk for hearing impairment and is the basis for referral for an audiological evaluation. This assessment may be done at the delivering hospital.

- History of any blood relative with childhood hearing impairment
- Congenital infection such as toxoplasmosis, syphilis, rubella, cytomegalovirus and herpes
- Defects of ear, nose, or throat
- Cleft palate (including submucous cleft)
- Pre-auricular pits or tags
- Any residual abnormality of the otorhinolaryngeal system
- Birthweight less than or equal to 1500 grams
- Hyperbilirubinemia at a level exceeding indication for exchange transfusion
- Severe asphyxia or depression at birth
- APGAR of 0-3 at 5 minutes or failure to institute spontaneous respiration by ten minutes
- Hypotonia persisting to two hours of age
- Bacterial meningitis
- Mechanical ventilation equal to or greater than ten days
- Syndromes known to include sensorineural hearing loss
- Children with neurodegenerative disorders
- Childhood infectious diseases, e.g. mumps, measles, chronic otitis
- Significant head trauma

References :

ACOG Compendium of Selected Publications (2003). 31 December, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Educational Bulletin (1998). Viral hepatitis in pregnancy. 248, July, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Practice Bulletin (1999). Management of herpes in pregnancy. 8, October, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Practice Bulletin (2000). The use of hormonal contraception in women with coexisting medical conditions. 18, July, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Practice Bulletin (2000). Perinatal Viral and Parasitic Infections. 20, September, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Practice Bulletin (2001). Assessment of risk factors for preterm birth. 31, October, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Practice Bulletin (2001). Chronic hypertension in pregnancy. 29, July, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Practice Bulletin (2001). Diabetes and pregnancy. 30, September, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Practice Bulletin (2002). Diagnosis and management of preeclampsia and eclampsia. 33, January, American College of Obstetricians and Gynecologists, Washington, D.C.

ACOG Technical Bulletin (1996). Hemoglobinopathies in pregnancy. 220, February, American College of Obstetricians and Gynecologists, Washington, D.C.

Cunningham, F. G., Gant, N. F., Leveno, et al. (2002) Williams Obstetrics, 22nd Edition. New York: McGraw-Hill.

Goldenberg, R. L. (1998) Low Birthweight in Minority and High-Risk Women. Patient Outcomes Research Team (PORT) Final Report. AHCPR Pub. No. 98-N005.

Koshy, M. (1999) Sickle Cell Disease and Pregnancy. Hematology, American Society of Hematology. 33-38.

Lu, G. C. & Goldenberg, R. L. (2000) Current Concepts on the Pathogenesis and Markers of Preterm Births. Clinics in Perinatology. 27, (2), 263-283.

Norwitz, E. R. & Robinson, J. N. (2001) A systematic Approach to the Management of Preterm Labor. Seminars in Perinatology. 25, (4), 223-235.

Public Health Service Task Force. (2002) Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States. February 4.

Rosenn, B. M. & Miodovnik, M. (2000) Medical Complications of Diabetes Mellitus in Pregnancy. Clinical Obstetrics and Gynecology. 43, (1), 17-31.

Schrag, S. J., Phil, D., Zell, E. R., et al. (2002) A Population-Based Comparison of Strategies to Prevent Early-Onset Group B Streptococcal Disease in Neonates. New England Journal of Medicine. 347, (4), 233-281.

SECTION 3

Administrative Policies and Guidelines

- Policy Guidance – Delegation of Nursing Tasks to Unlicensed Personnel
- Documentation by Exception
- Required Notification to Minors Choosing “Do Not Contact” Status
- Workplace Safety
- Case Management
- Eligibility and Sliding Fee Scale
- DMAS
- Clinical Lab Improvement
- IRB

Policy Guidance
Delegation of Nursing Tasks to Unlicensed Personnel
Virginia Department of Health

1. Definitions
   "Delegation" means the authorization by a registered nurse to an unlicensed person to perform selected nursing tasks and procedures.

   "Supervision" means guidance or direction of a delegated nursing task or procedure by a qualified, registered nurse who receives compensation, who provides periodic observation and evaluation of the performance of the task and who is accessible to the unlicensed person.

   "Unlicensed person" means an appropriately trained individual, regardless of title, who receives compensation, who functions in a complementary or assistive role to the registered nurse in providing direct patient care or carrying out common nursing tasks and procedures, and who is responsible and accountable for the performance of such tasks and procedures. With the exception of certified nurse aides, this shall not include anyone licensed or certified by a health regulatory board who is practicing within his recognized scope of practice.

   The "entity responsible for client care" is defined as the local health district.

   "Professional nursing" means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board of Nursing; or in the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing requires specialized education, judgment and skill based upon knowledge and application of principles from the biological, physical, social and behavioral sciences.

2. Criteria for Delegation:
   There must be a plan for delegation adopted by the district responsible for the client care. This district plan must contain the following:

   - An assessment of the client population to be served;
   - An analysis and identification of nursing care needs and priorities;
   - Organizational standards to provide for sufficient supervision that ensure safe nursing care of the needs of the clients in their specific settings;
   - Communication of the district delegation plan to staff;

- Identification of the educational and training requirements for unlicensed persons and documentation of their competencies.

3. The following are a list of tasks that may be delegated by a public health nurse to an unlicensed person in the Virginia Department of Health. This list is not inclusive of all tasks that may be delegated, but are examples of such tasks. Each district will have a local list of tasks that a public health nurse may delegate to an unlicensed person.

4. In all cases, the public health nurse will make the following assessment prior to delegating any nursing task to an unlicensed person:

   The delegating nurse shall assess the clinical status and stability of the client's condition, shall determine the type, complexity and frequency of the nursing care needed and shall delegate only those tasks which:

   - Do not require independent nursing judgment;
   - Do not require complex observations or critical decisions with respect to the nursing task;
   - Frequently reoccur in the routine care of the client or group of clients;
   - Do not require repeated performance of nursing assessments;
   - Utilize a standard procedure in which the tasks can be performed according to exact, unchanging directions; and
   - Have predictable results and for which the consequences of performing the task improperly are minimal and not life threatening.

   The delegating nurse shall also assess the training, skills and experience of the unlicensed person and shall verify the competency of the unlicensed person in order to determine which tasks are appropriate for the unlicensed person and the method of supervision required.

5. The delegating nurse shall determine the method and frequency of supervision based on factors to include, but not be limited to:

   - The stability and condition of the client;
   - The experience and competency of the unlicensed person;
   - The nature of the tasks being delegated;
   - The proximity and availability of the registered nurse to the unlicensed person when the nursing tasks will be performed.

6. An unlicensed person may not delegate a task for which he or she is responsible to another unlicensed person. In the event that the delegating nurse is not available, the delegation shall either be terminated or delegation authority shall be transferred by the delegating nurse to another public health nurse who shall supervise all nursing tasks as stated above.

7. The delegating public health nurse must monitor the performance of delegated tasks and ensure appropriate documentation. The delegating public health nurse must evaluate client outcomes and be accessible for consultation and intervention.

8. After ongoing assessment of the client's condition or the unlicensed person's competence, the public health nurse may determine that delegation of the task is no longer appropriate.

9. Nursing tasks that shall not be delegated to an unlicensed person are:

   - Activities involving nursing assessment, problem identification, and outcome evaluation that require independent nursing judgment;
   - Counseling or teaching except for activities related to promoting independence in personal care and daily living;
   - Coordination and management of care involving collaboration, consultation, and referral;
   - Emergency and non-emergency triage; and
   - Administration of medications except as specifically permitted by the Virginia Drug Control Act (§ 54.1-3400 et seq. of the *Code of Virginia*). The Virginia Drug Control Act cited is silent on the delegation of the administration of medication by unlicensed persons in the schools. Therefore, it is prohibited.

10. The public health nurse may teach unlicensed persons to administer medications and treatments to students in schools and may from time to time, review the procedures with the unlicensed persons to assess if more training is needed. Refer to the definition of "professional nursing" for clarification, specifically that nurses may "teach those who are or will be involved in nursing care." Teaching and supervising the instruction of an unlicensed person does not mean that the public health nurse is the delegating or the supervising nurse. If the public health nurse does not wish to be the supervising or delegating nurse, he or she should not serve on interview panels or provide input for or prepare the evaluation of the unlicensed person. If the nurse is performing the duties of a supervisor, he or she is the supervisor.

11. If a health director or nurse manager decides to allow public health nurses to delegate nursing tasks to unlicensed persons, the criteria outlined in number 2 of these guidelines must be met. The public health nurse will present a written record of how each of the criteria was met. That record should be retained in a place designated by the district. The delegating nurse must confirm that the unlicensed person has the necessary competencies for the particular task. A document outlining the training and return demonstration of these competencies should be in the public health nurse's and the unlicensed person's district personnel folder.

12. The "delegating" public health nurse retains the responsibility and accountability for the nursing care of the client.

Director's Comments:

Jeff Lake and Karen Connelly met with Robin Kurz, Assistant Attorney General, who confirmed that in those instances in schools when the principal or his designee assigns the performance of treatments to special needs students to one of his or her unlicensed staff, the school retains the responsibility of any adverse outcome, even if the procedure was taught to the unlicensed person by the public health nurse. However, if the district and the school choose to have the public health nurse be the delegating nurse, that liability transfers to the Department of Health.

Documentation that the public health nurse will delegate nursing tasks in the public schools must be retained at the district level.

Jeff Lake has made the decision to leave the question of whether or not to "delegate" at the district level. The Nursing Council concurs with that decision.

Keeping in mind that the decision as to whether to write a formal delegation plan is entirely at the district level, the Director offers the following guidance:

> For those tasks that unlicensed persons normally perform in local health departments, such as
> phlebotomy, taking vital signs, performing simple lab tests, etc. are not necessarily considered nursing tasks only, but are commonly taught in courses for unlicensed persons, that a delegation plan is not required.
>
> However, if a public health nurse, working in a school setting, delegates intermittent catheterization or any other special procedure to an unlicensed person, a full delegation plan should be written. This plan should be reviewed at least annually or more frequently if the delegating nurse chooses to do so.

Approved by Nursing Council 8/15/2002

DOCUMENTATION BY EXCEPTION MANUAL

The Virginia Department of Health has accepted documentation by exception as the preferred method for recording in the clinical record. A multidisciplinary team appointed by the Nursing Council in 1994 used the tools and philosophy of total quality management to design the system. The system is based on standards that define acceptable practice; minimum program requirements; and normal parameters for assessment, examination, intervention, expected patient responses and outcomes. The standards define the baseline of service for every patient served in any health department in Virginia. Forms were designed following these baselines which are used to note assessment, examination, intervention and expected patient responses in the areas indicated by using a check mark. An asterisk instead of a check indicates that the patient response was not normal, or that the provider omitted something that is required by the standard. In most cases, the asterisk indicates the reader should look somewhere else for clarification. No entry indicates "not required by the standard" and does not require further documentation. This system has been approved by VDH's Assistant Attorney General.

References : VDH Internal Web, http://vdhweb/nursing/except.asp.

Limits on Confidentiality for Minors Choosing "Do Not Contact" Status

VDH Policy Number 2003-4 June 24, 2003

"Do Not Contact" (DNC) status governs the method by which patients are billed and contacted. This status is used to provide an additional level of confidential services to patients upon their request.

1. Minors who are seen as DNC patients must be informed of the advantages of involving their parents or guardian in the minors' medical care. (Note: in the rest of this document, "parent" should be read to mean "parent or guardian or other person authorized to consent to treatment of minors pursuant to 54.1-2969.") VDH employees should also inquire about the reasons DNC status is requested to help the minor determine if those reasons are valid. The advantages of parental involvement include:

   a. Parents may be the sole source of important medical history.
   b. Parents may be able to help the minor by asking questions and exploring options, as well as providing better decision making.
   c. Parents may be able to put the minor's situation in a broader context, again leading to better decision making.
   d. If the parents find out from a source, other than the minor, that the minor received confidential services, the minor's relationship with the parents may be compromised.

2. When parents ask if their minor child is receiving care at the health department or if they want to review or obtain a copy of the minor's medical record, they should be told

that if VDH can verify that they are the parents (see below), their questions will be answered and they can have access to the record, unless the minor received services under Title X (see exception below). It should be mentioned that the minor may have responsibly sought medical care. Also, obtaining information without the minor's consent might make their relationship more difficult. Parents should also be informed that VDH believes it is appropriate and prudent to notify the minor before releasing information and this will also give the minor the chance inform their parents directly. The encounter should be used to assist both the minor and parent in strengthening the family relationship. Through such a discussion it may be possible to identify and address concerns, possibly eliminating the need to confirm clinic attendance or to release the record.

3. Parent relationships are most easily verified by questioning the minor. If that is not possible, documentary evidence such as a birth certificate, school records, or similar documentation must be provided. The documents need to confirm both the identity of the requester and his or her relationship to the minor patient.

4. If the parent can verify his or her relationship to the patient and requests to view the record, he or she should be informed that they have that right. And, although the minor does not have to give his or her permission for the parent to see the record, VDH employees are expected to verify that agency records release policies are being followed appropriately and to verify that no new information is available that might modify or prohibit release. VDH can take up to 5 days to complete verification, but must balance the need to take that much time against the expressed needs of the parents.

5. Providing medical record information, or confirming or denying a patient's attendance at clinic, cannot be provided over the phone as the caller's identity cannot be established, but parents can be told what documents to bring with them to establish the parental relationship if they want to see the record. It must be made clear that providing such guidance does not confirm that the minor has attended a VDH clinic or that VDH has a medical record for the minor.

6. If the parents are separated or divorced, both parents have access to the minor's records, but only the custodial parent (in addition to the minor) can authorize release of the record to others.

7. It is reasonable to delay release of medical records to the parents to give the minor the chance to let us know if they are at risk because their home environment has become destabilized in terms of violence, abuse, or neglect; or to survey the staff for such information. However, any such delay must take place within the 5-day verification period discussed in paragraph 4. In cases where VDH staff become aware of such information on any minor DNC patient, the chart should be flagged when the information is obtained. Do not rely on a last minute poll of staff to identify patients at risk as a result of a medical record release. When the release of flagged records, or records otherwise identified as belonging to a patient at risk, is requested, the district director must be contacted immediately. In such cases, the district must consult with the Deputy

Commissioner for CHS or Public Health Programs. When evidence of violence, abuse, or neglect is discovered, a Child Protective Services referral is indicated.

8. Minors who are deemed adults for consenting to medical or health services under §54.1-2969 (E) of the Code of Virginia must be advised that the law does not reduce their parents' rights to access the minors' medical records, except in the case of family planning services provided under Title X. The law states that:

> E. A minor shall be deemed an adult for the purpose of consenting to:
>
> > 1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease that the State Board of Health requires to be reported;
> > 2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;
> > 3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in §37.1-203;
> > 4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance; or
> > 5. The release of medical records related to subdivisions 1 and 2.

This law does not convey any confidentiality rights and E.5 does not remove the parental right of access, it simply allows the minor to authorize release to those other than the parents. Also, §32.1-36.1 does not restrict parent's rights to HIV results.

9. VDH extends confidentiality for the purposes of completing the lawful medical and health care services under §54.1-2969 (E) by granting DNC status. This confidentiality is limited and conditional. When the services exceed the reasonable expected limits of the purposes listed above, the ability of the minor to continue to consent is questionable and confidentiality may not be safely maintained. Examples could include a pap smear needing follow-up and the patient refusing to keep her appointments, pap smear testing leading to a cervical biopsy, positive HIV test results, and hypertension or other chronic diseases diagnosed for the first time. The DNC patient must be notified that, under conditions such as these, parental involvement may be required. Every reasonable effort must be made to inform the minor before disclosing anything to the parents in order to give the minor the chance to let his or her parents know or to give the minor the chance to let us know if his or her home environment has become destabilized in terms of violence, abuse, or neglect.

10. This policy does not apply to substance abuse records. Minors have a federal right of privacy granted in 45 C.F.R. 2.14. If a minor had only received substance abuse treatment (an extremely unlikely event for the health department), VDH cannot confirm the minor has received services or that VDH has a medical record for the minor.

11. EXCEPTION: All patients, including minors, receiving any services funded by Title X are entitled to confidentiality and the parents of minors cannot access their minor

children's records unless the minor agrees. This confidentiality also includes not confirming clinic attendance. When minors receive services funded by Title X and services funded from other sources (i.e. family planning visits and separate STD visits), the medical record should be organized such that services received under Title X could be excluded from release to the parents.

Workplace Safety

National Institute for Occupational Safety and Health (NIOSH) was established by the Occupational Safety and Health Act of 1970, which also established the Occupational Safety and Health Administration (OSHA). Although NIOSH and OSHA were created by the same act of Congress, they are two distinct agencies with separate responsibilities. NIOSH is in the U.S. Department of Health and Human Services and is a research agency. OSHA is in the U.S. Department of Labor and is responsible for creating and enforcing workplace safety and health regulations. NIOSH and OSHA often work together toward the common goal of protecting worker safety and health.

References :

National Institute for Occupational Safety and Health, Retrieved December 20, 2002 from http://www.cdc.gov/niosh/healthpg.html

U.S. Department of Labor, Retrieved December 20, 2002 from http://www.osha.gov/

CASE MANAGEMENT

Case management may be defined and practiced in a variety of ways and settings. The American Nurses Association defines case management as a system of health care delivery designed to facilitate achievements of expected patient outcomes within an appropriate length of time, with goals of quality care, decreased fragmentation, enhanced quality of life, the efficient use of resources, and cost containment. (Ling 2002. p. 1) The Case Management Society of America defines case management as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individuals health needs, using communication and available resources to promote quality, cost effective outcomes. (Ling 2002. p. 1) Case management is the provision of services in a coordinated culturally sensitive approach through client assessment, referral, monitoring, facilitation, and follow up on utilization of needed services, according to the Healthy Start Division of Perinatal Systems and Women's Health. (October 2002) The Center for Medicare and Medicaid Services (2002, p. 1) defines case management as a process used by a doctor, nurse, or other health professional to manage health care, and the case manager makes sure that individuals get the needed services, and tracks utilization of facilities and resources.
In 1992 the Virginia Department of Health (VDH) published a Case Management Manual and included elements from the definitions above in its definitions. The VDH Case Management Manual (1992, p. 6) notes that case management is a practice performed by professionals with varying backgrounds to facilitate the delivery of coordinated, comprehensive, efficient, and appropriated service to individuals and families. Three modes are mentioned in the manual for the case management process/system. Programs offering case management will select the model appropriated for their clients/target population and health care network, and community resources/services. (Balingit 2001)

A case management model and process determines caseload size, assessment, services, and referrals. (VDH 1992, p. 14) An assessment of the client's needs determine their risk level, appropriate services and referrals. (VDH 1992, p. 21) The VDH Case Management Manual (1992, p. 17-18) describes "Tiers" used to identify risk level, duration, and intensity of services. Use the risk screening tool, standards of care, and documentation identified in the Documentation by Exception Records System Manual. The service plans in the VDH Case Management Manual is the protocol to guide Case Managers and Care Coordinators actions, interventions, follow up, and evaluation of the individual and/or family participating in health department services. Health Care Professionals are to follow up on the risk screening, complete a comprehensive assessment, and make appropriated referrals. (ANA 1994, p. 5) Case management based on local health districts' discretion.

References :

American Nurses Association. (1994). Managed Care: Nursing Facts: Managed Care: Challenges & Opportunities for Nursing. Retrieved November 25, 2002, from http://nursingworld.org/readroom/fsmgdcar.htm

Balingit, R. (2001). The American Institute of Outcome Case Management. Case Management Challenges in Population-Based Care. Retrieved November 22, 2002, from http://www.aiocm.c…/Case%20Management%20Challenges%20in%20Pobulation%Based%20Care.htm

Centers for Medicare & Medicaid Servides. (2002). Glossary. Retrieved November 27, 2002, from http://cms.hhs.gov/glossary/default.asp?Letter=C&Language=English

Flarey, D. L., & Blancett, S.S. (1966). Handbook of Nursing Case Management. Gaithersburn, Md.: Aspen Publishing Co.

U.S. Department of Health & Human Services (HRSA). (2002). Interconceptional Care For High Risk Women and Infants. 2002 Healthy Start Grantee Meeting, Baltimore, Maryland 6-9 October 2002. HRSA Maternal and Child Health Bureau: Healthy Start Division of Perinatal Systems and Women's Health. Learned Information.

JAMA. (1999). The Value of Targeted Case Management During Transitional Care. Retrieved November 22, 2002, form http://jama.ama-assn.org/issues/v281n7/ffull/jed90002.html

Ling, C. (2002). Case Management Basics. Retrieved November 22, 2002, from http:// nurse.cyberchalk.com/nurse.course/nurseweek/nw2210/course.htm

Virginia Department of Health (VDH). (1992). Case Management Manual. Richmond, Virginia: VDH.

Requirements for Fee Adjustments

** You must pay for services at the time of the visit and MUST bring **Proof of Income** (**see the list below, one or more can apply to you**). If you do not bring proof, you can pay **Full Fee** OR be rescheduled. All Proof of Income will be verified. Fees for some services may be adjusted according to income by providing one of the following:

1. WORK? Paycheck stubs from the past three pay periods.

2. NO PAY STUBS? A letter on company letterhead, signed by the supervisor, and phone number given, that states date of employment, the gross and net pay for the past 3 paydays and how many hours worked; OR the most recent **filed** federal income tax return; OR all W-2 withholding forms (from each job held) from the previous year.

3. MARRIED? Income verification for your husband and yourself if you work.

4. YOU and/or YOUR HUSBAND NOT WORKING? Termination letter that states the last day of work and a letter from the person who is supporting you.

5. NOT MARRIED, and not working - Signed letter from the person who is supporting you that includes phone number, relationship to you and how long they plan to support you.

6. GETTING UNEMPLOYMENT? Bring a letter from the Virginia Employment Commission and forms approving/denying unemployment or workers' compensation.

7. GETTING CHILD SUPPORT? Bring the court order showing how much you get in child support.

8. HAVE INSURANCE? BRING THE CARD. If card says "PCP" or "HMO", it should tell you where to go for care. If you come here you will have to pay the FULL FEE. Other types of insurance? Bring the card and proof of income. You are responsible for the co-pay and the cost of the visit.

9. A written statement from Social Services.

10. Provide documentation of SSI or Disability.

11. Medicaid cardholders are eligible for medical services. Medicaid care must be presented at each visit.

12. For information call the health department in your community.

References : 12 VAC 30-20-10 et seq. Administration of Medical Assistance Services

Department of Medical Assistance Services (DMAS)

DMAS oversees Medicaid and Family Access to Medical Insurance Security (FAMIS). FAMIS provides health benefits for children who are uninsured, but who are not eligible for Medicaid. Medicaid is an assistance program that helps pay for medical care. To be eligible for Medicaid you must have limited income and resources, and you must be in one of the groups of people covered by Medicaid. Some groups covered by Medicaid are: pregnant women, children and people with disabilities. Any newborn whose mother is a Medicaid enrollee in the Contractor's plan on his or her date of birth shall be deemed an enrollee of that plan for three months. The newborn's continued enrollment with the Contractor is not contingent upon the mother's enrollment. For more information, contact Virginia Department of Medical Assistance Services at 804-786-4231, website www.dmas.state.va.us.

The Virginia Medicaid Handbook provides information on eligibility, services, how to apply for assistance, and co-payments. Some Medicaid recipients must pay a small amount for services; this is called a co-payment. Medicaid is not an insurance plan, but an entitlement program funded by the state and federal governments. The handbook is a useful tool that contains most of what you would like to know about the program. Medicaid rules change and there are many circumstances that affect eligibility. Apply for Medicaid at a local Department of Social Services office. Local Department of Social Services offices take applications and make eligibility decisions. DMAS pays the physicians, hospitals, pharmacies or other medical services providers for care and services received by Medicaid-eligible individuals. DMAS administers three managed care programs, specific to geographic location. They are MEDALLION, Options and MEDALLION II. Virginia has two children's health insurance programs that provide health insurance to children under age 19 years; they are Medicaid and FAMIS. FAMIS provides health benefits for children who are uninsured, but who are not eligible for Medicaid.

Virginia's Administrative Code 12VAC30-50-310 describes emergency services for aliens. "No payment shall be made for medical assistance furnished to qualified aliens who entered the United States on or after August 22, 1996, who are eligible for Medicaid for five years after their entry, and nonqualified aliens, including illegal aliens and legal nonimmigrants who are otherwise eligible, unless such services are necessary for the treatment of an emergency medical condition of the alien."

CLIA

The Clinical Laboratory Improvement Act (CLIA) was established as a guideline for laboratories to follow. The Centers for Medicare and Medicaid Services regulate all laboratory testing (except research) performed on humans in the U.S. through CLIA. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

INSTITUTIONAL REVIEW BOARD (IRB)

One of the many ways the Virginia Department of Health (VDH) serves the public and fulfills its mission is through research. Research is defined in federal regulations as a systematic investigation designed to develop or contribute to generalizable knowledge. Periodically VDH conducts research that involves human subjects. VDH considers the protection of human subjects as important as the methodology, research findings, or any other component of the research project.

VDH has developed policies and procedures to ensure that the rights and welfare of human subjects involved in research are protected and consistent with both state (12 VAC 5-20-10) and federal (45 CFR Part 46) regulations. The Office for Human Research Protections (OHRP), under the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Health, is responsible for ensuring the safety and welfare of people who participate in HHS-sponsored research. Policies, guidelines and regulations from OHRP, including the ethical principles found in the Belmont Report, provided the framework for the development of the state regulations, and provide the structure for VDH review and approval of human subjects research.

A major component of the process for ensuring the protection of the rights and welfare of human subjects involved in VDH research is the Institutional Review Board (IRB), also known as the research review committee. Research protocols must be either approved or granted an exemption by the IRB before human subjects can begin participation. The IRB also conducts continuing review of each approved protocol at least annually. The IRB may modify, suspend or terminate approval of research that has been associated with serious harm to subjects or is not being conducted in accord with the IRB's decisions, stipulations, and requirements.

In general, any research that is conducted by VDH, by outside investigators in collaboration with VDH, or by outside investigators using VDH data, is subject to review and approval by the VDH Institutional Review Board (IRB). For specific information, consult the VDH IRB Guidelines and Procedures for Obtaining Review, which can be found in its entirety on the VDH internal web at http://vdhweb/irb/irb.htm. If you have any questions or need assistance, contact:

Kathy H. Wibberly, Ph.D.
Chair, VDH IRB
Virginia Department of Health
Office of Health Policy and Planning
109 Governor Street, 10th Floor
PO Box 2448
Richmond, VA 23218-2448
Phone: 804-864-7429
Fax: 804-864-7740
Email: Kathy.Wibberly@vdh.virginia.gov

SECTION 4

Division Resources and Programs

- Family Planning
- Sterilization
- Pap Smear Screening
- Regional Perinatal Councils
- VASCAP
- Resource Mothers
- BabyCare
- Virginia Healthy Start Initiative
- Bright Futures
- Breast and Cervical Cancer Early Detection Program

Family Planning

Eligible low-income citizens receive comprehensive family planning services. The goal is to assist women in spacing out their pregnancies or preventing undesired pregnancies. All local health departments, except for the Fairfax and Richmond City Health Departments, provide Family Planning services, internally which include:

- health education
- pregnancy diagnosis and counseling
- complete medical history
- physical assessment
- routine laboratory testing
- a wide choice of contraceptive methods, including DepoProvera and sterilization
- treatment of routine gynecologic problems including sexually transmitted diseases
- referral and follow-up for other identified problems
- infertility services are referred

Fairfax and Richmond City Health Departments provide services through local contractual arrangements.

Contact: Barbara Parker, RN, MPH, 804-864-7753, BarbaraE.Parker@vdh.virginia.gov, and E. Anne Elam, RN, MPH, Cervical Cancer Program, 804-864-7754, Anne.Elam@vdh.virginia.gov, website www.vdh.virginia.gov.

Sterilization

This program offers voluntary sterilization services for men and women who meet the Commonwealth's eligibility requirements and are not eligible for Medicaid. Annually, the Department provides funding for a limited number of qualified Virginia residents who request permanent sterilization.
Contact: Ardriene Stuart, 804-864-7755, Ardriene.Stuart@vdh.virginia.gov, website www.vdh.virginia.gov.

Pap Smear Screening

All local health departments receive funding for Pap smear screening. Prevention through health education is stressed. Staff monitor all abnormal Pap results, refer patients as indicated and provide follow-up care.
Contact: Anne Elam, RN, MPH, 804-864-7754, Anne.Elam@vdh.virginia.gov, website www.vdh.virginia.gov.

Regional Perinatal Councils

The perinatal regions were identified based upon neonatal transport patterns. These councils make up a statewide network of public/private partnerships that assess the needs of infants and women of reproductive age. Their purpose is to coordinate community health care systems that serve women and infants and develop improved solutions to achieve healthier infants. Some individuals and organizations that participate in these

efforts include parents, health professionals, medical school faculty, health and human service organizations, religious groups, businesses, schools and community leaders. Health department staff should be involved in various activities of the councils in their regions. The RPCs are responsible for the Fetal and Infant Mortality Review Program (FIMR) and for perinatal outreach education. FIMR is a collaborative project between the American College of Obstetricians and Gynecologists and the federal Maternal and Child Health Bureau. The Virginia FIMR is based upon the national model and has been administered by the RPCs since 1996. It is a community-based program that analyzes the circumstances surrounding infant deaths and activates the community to seek ways to prevent those deaths. FIMR collects data from medical records and mother interviews on selected cases. The knowledge gained helps the state improve programs and systems of care for mothers and babies. By utilizing the findings and insights gained through FIMR, the RPCs develop work plans to address the identified perinatal issues for their regions. Grants and other funding sources are sought to implement the local projects as developed by these local coalitions. Perinatal educational activities are planned as determined by the learning needs assessed through FIMR and yearly provider surveys. (see Appendix N for local contact)
Contact: Theresa Taylor, Perinatal Nurse Consultant, 804-864-7767, Theresa.Taylor@vdh.virginia.gov, website www.vdh.virginia.gov.

Virginia Sickle Cell Awareness Program (VASCAP)
The Virginia Sickle Cell Awareness Program is designed to offer access to current and accurate information regarding sickle cell disorders and other hemoglobin variants through collaboration with Family Planning and Maternity clinics in both the public and private sector and community and professional education programs. Other services offered through VASCAP include educational genetic counseling and screening for individuals unable to pay for the services offered, e.g., medical and social referrals for individuals and families coping with sickle cell disease, coordination of newborn case management services through referrals to a network of five Pediatric Comprehensive Sickle Cell Centers located throughout the state. The VASCAP program manager tracks all newborns identified through Virginia's Newborn Screening Program to assure timely entry into care.
Contact: Newborn Screening Lab Contact: Howard Conway, (804) 648-4480, ext. 182. Jene Radcliffe-Shipman, Program Manager, 804-864-7769, Jene.Radcliffe-Shipman@vdh.virginia.gov, website www.vdh.virginia.gov.

Resource Mothers
The program uses community mentors to provide intensive home visiting services to young pregnant women and mothers through the infant's first birthday. The goals are to decrease infant mortality and morbidity and to decrease the rate of low birthweight babies born each year, to delay repeat pregnancy, to keep teens in school, and involve the infant's father in parenting his child. There are programs in over half of Virginia's localities.
Contact: Cathy Bodkin, LCSW, MSHA, 804-864-7768, Catherine.Bodkin@vdh.virginia.gov, website www.vdh.virginia.gov.

BabyCare

The BabyCare Program provides intensive case management services to pregnant women and women at risk of poor outcomes. The target population is Medicaid recipients. It is operated by local health departments and funded by the Department of Medical Assistance Services (DMAS). It is overseen by the Division of Women's and Infants' Health and DMAS. Services include risk assessment, coordination of services, follow-up and monitoring. Education and counseling are also provided when needed. BabyCare is implemented at various levels throughout the state. High-risk clients receive risk appropriate services that include case management, nutrition counseling, prepared childbirth, parenting, smoking cessation, education, transportation and homemaker services if indicated.

Contact: Cathy Bodkin, LCSW, MSHA, Program Coordinator, 804-864-7768, Catherine.Bodkin@vdh.virginia.gov, website www.vdh.virginia.gov.

Virginia Healthy Start Initiative

The Virginia Department of Health (VDH) Healthy Start Initiative began in 1997 as a grant from the Health Resources and Services Administration. Virginia's Healthy Start program is a part of a nationwide effort to promote greater infant health, reduce infant mortality and low birth weight in three urban areas (Norfolk, Petersburg, Portsmouth) and one rural area (Westmoreland County). The primary thrust of the Virginia Healthy Start Initiative (VHSI) is to eliminate disparities in health care and to increase penetration of project services within the VHSI target sites, encourage women to seek early and regular prenatal care, and to enhance provider sensitivity to cultural diversity and the needs of families living in poverty. To achieve these goals, VDH is working through existing programs (Regional Perinatal Councils, FIMR, Resource Mothers, and Nutrition Services). The initiative will support the expansion of:

- the Resource Mothers Program to include women up to the age of 24
- nutrition services for pregnant women and infants
- the Fetal-Infant Mortality Review (FIMR) program
- education and public awareness of the issue of infant mortality and morbidity and its prevention.

Contact: Linda Foster, Virginia Healthy Start Initiative Coordinator, 804-864-7764, Linda.Foster@vdh.virginia.gov, website www.vdh.virginia.gov.

Bright Futures Virginia

Bright Futures provides an expert set of guidelines and a practical developmental approach to providing health supervision for children from birth through adolescence. Bright Futures is dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health care.

The mission of Bright Futures is to promote and improve the health, education, and well being of infants, children, adolescents, families, and communities. The core concepts are that prevention works, families matter, and health is everyone's business.

The goals of Bright Futures are to:

- Foster partnerships between families, health professionals, and communities.

- Promote desired social, developmental, and health outcomes of infants, children, and adolescents.
- Increase family knowledge, skills, and participation in health promotion and prevention activities.
- Enhance health professionals' knowledge, skills, and practice of developmentally appropriate health care in the context of family and community.

Bright Futures was adopted as the standard of care for Virginia's children and adolescents by:

- Virginia Department of Health
- Virginia Department of Education
- Virginia Department of Medical Assistance Services

Contact: Cathy Bodkin, LCSW, MSHA, 804-864-7768, Catherine.Bodkin@vdh.virginia.gov, website www.vahealth.org/brightfutures/index.htm.

Virginia Breast and Cervical Cancer Early Detection Program (BCCEDP) also known as Every Woman's Life

The Virginia BCCEDP is funded through a grant from the Centers for Disease Control and Prevention to provide pelvic exams, Pap tests and mammograms free of charge to eligible women. There are 26 Administrative Provider Sites located throughout the Commonwealth of Virginia that are contracted to provide these services. Clients who are screened through the Virginia BCCEDP, diagnosed with cancer or a pre-cancerous condition and certified as needing treatment by a BCCEDP Provider may be eligible for payment of that treatment by Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

Eligibility criteria for the BCCEDP are as follows:

a. Female gender
b. Age 50-64 (A limited number of women 40-49 may qualify based on appointment availability)
c. Self-declared income must be 200% of Federal Poverty Level or less
d. Primary Residence in Virginia (self-declared)
e. Uninsured or Underinsured (self-declared)

For more information, visit our web site at www.vahealth.org/breastcancer. You may reach program staff as follows:

Kathy Heise, Program Director	804-864-7756
Beth Ehrensberger, Public Education Manager	804-864-7759
Fran Darlington, Quality Improvement Nurse Manager	804-864-7758
Gail Jennings, PhD, Data, Surveillance and Evaluation Manager	804-864-7758

Women interested in referral to a participating provider should call 1-866-EWL-4YOU (4968).

SECTION 5

Child and Adolescent Health
- Child Development Clinics
- Pediatric Screening and Genetic Services (PSGS)
- Virginia Genetics Program
- Virginia Newborn Hearing Screening

Child and Adolescent Health

Child Development Clinics

The Child Development Clinics (CDC) are a statewide network of eleven publicly-funded pediatric specialty clinics serving children with known or suspected developmental disorders including mental retardation, communication disorders, learning problems, childhood behavioral, emotional, or mental health disorders, neurological disorders, primary sensory, motor, physical disorders or a combination of these problems.

The mission of the CDCs is to increase the availability and accessibility of comprehensive, interdisciplinary developmental services to appropriate children to promote their optimal physical, social, mental, and emotional development and well-being.

One goal of the clinics is to improve the early identification of children who are at greatest risk for developmental disorders and in need of developmental services. A second goal is to increase the availability and accessibility of comprehensive interdisciplinary developmental services to appropriate children.

The clinics serve Virginia residents from birth through 20 years of age with a suspected or known developmental delay or disorder, behavioral disorder, learning disorder, mental retardation, neuropsychological disorder or presence of severe or multiple risk factors for these conditions.

The clinics diagnose developmental problems including delays in maturation or deviant maturation in physical, social, mental, educational, behavioral, or emotional development to the extent that there is a negative impact on the child's ability to adapt to or cope with the typical environmental demands as expected for chronological age.

The clinics provide a comprehensive evaluation by a team of clinicians. The team usually consists of a pediatrician or nurse practitioner, nurse, clinical social worker, education consultant, and clinical or school child psychologist. This interdisciplinary team provides individual treatment plans for children with developmental disorders. The CDCs are part of VDH's Children with Special Health Care Needs (CSHCN) Program. This program is funded through a combination of federal Title V Maternal and Child Health Block Grant funds and State general funds.

Contact: Carol Pollock, RN MSN, FNP, School Age and Adolescent Health Nurse Consultant, Division of Child and Adolescent Health, 804-864-7685, website: www.vdh.virginia.gov.

Pediatric Screening and Genetic Services (PSGS)

Health Issue

There are approximately 95,000 live births in Virginia each year. Of these births, an

estimated 3,700 are born with disorders that may impede their ability to hear, learn, and grow into healthy children and adolescents.

Mission

Pediatric Screening and Genetic Services' (PSGS) focus is to reduce the occurrence and impact of birth defects among children and their families.

Functions

- Assessing pediatric congenital anomalies, including inborn errors of body chemistry and hearing disorders.
- Identifying pediatric screening and genetic resources.
- Informing the public about pediatric screening and genetic services.
- Assisting policy makers in developing pediatric screening and genetic services-related policies.
- Supporting private and public healthcare providers.
- Developing programs and information systems, including the Virginia Infant Screening and Infant Tracking System (VISITS). VISITS is a web-based tracking and data management system that supports the following statewide services:
  (1) Virginia Early Hearing Detection and Intervention Program
  (2) Virginia Congenital Anomalies Reporting and Education System
  (3) Virginia Newborn Screening Services
  (4) Infant & Toddler Connection of Virginia (via electronic referrals).
  Website:
  www.welligent.com/visits.

Organization

Pediatric Screening and Genetics Services includes the following programs:

- Virginia Early Hearing Detection and Intervention Program
- Virginia Genetics Program

Contact: Nancy Ford, MPH, RN, Director of Pediatric Screening and Genetic Services, 804-864-7691, Nancy.Ford@vdh.virginia.gov. Website: www.vahealth.org/psgs/

<u>Virginia Genetics Program</u>

The goal of the Virginia Genetics Program is to reduce unnecessary morbidity and mortality from potential or existing genetic conditions by assuring that necessary, high quality, effective genetic health services—including appropriate education, testing, counseling, and treatment—are available to the citizens of the Commonwealth.

Health Issue

- In Virginia, as elsewhere in the United States, birth defects are the leading cause

of death in the first year of life. Each year in Virginia about 4,600 infants are born with birth defects, of which about 270 infants die before 2 years of age.

- Note: A birth defect is defined as a serious structural, functional, or biochemical abnormality due to genetic, nutritional, or environmental factors, or any combination of the above, that is present at birth even though it may not be manifested until later in life. Such defects range from minor to severe and may result in a physical or mental disability, or early death. The terms "congenital anomaly" and "congenital malformation" are also used to describe such conditions.

Components

- Virginia Newborn Screening Services: Virginia Newborn Screening Services finds those few infants who have the following birth defects. Finding these infants and giving them early treatment prevents serious complications, such as mental retardation, permanent disabilities, or even death. Newborn screening is offered to families with new babies as a service through the Virginia Department of Health. The initial screening tests are performed by the Virginia Department of General Services, Division of Consolidated Laboratories (DCLS), which is located in Richmond. DCLS also performs repeat tests on infants up to 6 months of age. Every infant in Virginia is tested for the following errors of inborn chemistry a few days after birth unless a parent or guardian objects on the grounds that the test conflicts with their religious practice.

  1. Biotinidase Deficiency
  2. Congenital Adrenal Hyperplasia (CAH)
  3. Congenital Hypothyroidism
  4. Galactosemia
  5. Homocystinuria
  6. Maple Syrup Urine Disease (MSUD)
  7. Phenylketonuria (PKU)
  8. Hemoglobinopathies (including Sickle Cell Disease)
  9. Medium-chain acyl-CoA dehydrogenase deficiency (MCAD deficiency)

- Metabolic Treatment Services/Phenylketonuria (PKU) Management:
  1. Metabolic treatment services, including long-term medical management including management of the required metabolic formulas for PKU, MSUD and Homocystinuria, are available for infants and children in medically indent families from the following health care providers:
  a. University of Virginia
  Division of Medical Genetics
  Department of Pediatrics
  b. Virginia Commonwealth University Medical Center
  School of Medicine, Department of Pediatrics

  2. The cost of modified low protein food products required in the management of phenylketonuria are reimbursed to

a. The parents or guardian of any child.
b. Any pregnant woman, who is a legal resident of the Commonwealth and who is diagnosed
as requiring treatment for phenylketonuria.

- Virginia Congenital Anomalies Reporting and Education System (VaCARES): VaCARES is a birth registry of children under 2 years of age who have a congenital anomaly. VaCARES collects epidemiological data and lets families know about treatment programs.

- Regional Genetic Centers: There are three regional genetic centers that provide genetic testing, counseling, and education for all residents, especially those with very limited resources. (Planning is being done to add a pediatric-serving genetics center in Northern Virginia.)

1. Virginia Commonwealth University Medical Center
   Genetics Program
   P.O. Box 980033
   Richmond, Virginia 23298

2. Eastern Virginia Medical School
   Department of Pediatrics
   Division of Medical Genetics
   601 Children's Lane
   Norfolk, Virginia 23507-1921

3. University of Virginia
   Division of Medical Genetics
   Department of Pediatrics
   Box 386
   Charlottesville, Virginia 22908

- Virginia Genetics Advisory Committee: The Committee coordinates access to clinical genetic services across Virginia, assuring the provision of genetic literacy, and quality services and education for consumers and providers taking into consideration issues of confidentiality, privacy, and individual consent. Members include representatives from VDH; Virginia Department of General Services, Division of Consolidated Laboratory Services; Virginia Genetic Centers; Virginia Department of Education; March of Dimes, Virginia Chapter. (Membership is being expanded to include parents and medical associations, and other pertinent organizations.)

Contact: Sharon Williams, M.S., R.N., Virginia Genetics Program Manager, 804-864-7712, SharonK.Williams@vdh.virginia.gov, website http://www.vahealth.org/genetics/

Virginia Newborn Hearing Screening

Goal

The goal of the Virginia Early Hearing Detection and Intervention Program is to identify congenital hearing loss in children by 3 months of age and enroll them in appropriate early intervention by 6 months of age.

Health Issue

- Nearly 300 babies are born in Virginia each year with some form of hearing loss—making hearing loss the most frequently occurring birth defect both in the Commonwealth and nationally.
- Experience and research have shown that early detection of hearing loss is essential for promoting the development of infants and toddlers. Conversely, postponed detection of hearing loss often results in developmental delays.

Components

- Universal Newborn Hearing Screening: Screening every newborn for hearing loss prior to hospital discharge.
- Monitoring and Follow-Up: Ensuring that babies who miss their initial newborn hearing screening prior to hospital discharge receive a screening by the age of 1 month, and/or that children who pass their screenings but have known risk indicators for progressive or late-onset hearing loss receive ongoing assessment through 6 years of age.
- Diagnostic Audiology: For those infants who refer following their newborn hearing screening, conducting a diagnostic audiological evaluation before 3 months of age to confirm and quantify/qualify (i.e., determine the type, degree and configuration of) the hearing loss and to assist families in identifying appropriate amplification and/or communication methods.
- Care Coordination: Promoting the concept of the medical home to ensure that other evaluations (e.g., vision and genetics screenings) are conducted, as appropriate, and to coordinate the overall health care needs of children who have hearing loss.
- Early Intervention: Enrolling infants with hearing loss in early intervention services by 6 months of age.

Contact: Pat Dewey, M.Ed., Virginia Early Hearing Detection & Intervention Program Manager, 804-864-7713, pat.dewey@vdh.virginia.gov, website www.vahealth.org/hearing.

SECTION 6
Women, Infants, and Children (WIC) and Community Nutrition Services

Women, Infants, and Children and Community Nutrition

Women, Infants, and Children and Community Nutrition
The WIC program provides high quality nutritional care and food to low income pregnant, breastfeeding, and postpartum women and children up to age five. The program provides milk, cheese, eggs, juice, cereal, dried beans or peas, and peanut butter. Vouchers for iron-fortified formula are also provided.

The Virginia WIC Program promotes breastfeeding:

- as the preferred infant feeding method
- by creating a positive health care setting environment
- by providing information on the health benefits of breastfeeding
- by supporting breastfeeding women through the peer counselor program.

Goals

- To improve infant and family health by making breastfeeding the cultural norm
- To improve the rates of breastfeeding initiation and duration in Virginia's WIC program to meet the National Healthy People 2010 Breastfeeding Objective of:
    - 75% of women breastfeeding at hospital discharge
    - 50% breastfeeding their infants at 6 months and
    - 25% breastfeeding their infants at 1 year of age.

Administration

The breastfeeding promotion of the WIC program is administered through the Division of WIC and Community Nutrition at the Virginia Department of Health.

Breastfeeding Friendly

All clinics in local health departments are monitored to be "Breastfeeding Friendly."

- Positive breastfeeding messages must be included in educational activities materials, and outreach efforts.
- Formula advertisements and cans must not be visible in clinics.
- Clinics must provide a comfortable, discreet area for clients to breastfeed.

Pump Loan Program

Electric breast pumps are loaned and attachment kits given to breastfeeding WIC moms if they need to be away from their babies for long periods of time to establish, maintain, or collect breast milk.

Manual pumps are also given to moms who request it for their personal use and are not

reused.

Other breastfeeding equipment is available for WIC moms if needed.

WIC Breastfeeding Benefits

- Breastfeeding women receive WIC benefits up to one year whereas non-breastfeeding women are eligible for only 6 months.
- Breastfeeding women receive more variety and quantity of food than do non-breastfeeding women.
- Breastfeeding women who exclusively breastfeed (babies receive no formula on WIC) receive a food package which includes tuna fish and carrots.

Contact: Lisa Armstrong, WCNS Program Manager, 804-864-7840, lisa.Armstrong@vdh.virginia.gov, website www.vahealth.org/wic/bfwic/index.htm.

SECTION 7
Center for Injury and Violence Prevention

Center for Injury & Violence Prevention

Center for Injury and Violence Prevention
Sexual Violence Prevention
Sexual violence is a crime of violence, power and control. Sexual violence includes rape, sexual assault, sexual harassment and child molestation. Sexual violence affects us all. Women, men and children can be victims of sexual violence. According to the 2000 FBI report, there were 90,186 forcible rapes of adult females that were reported to law enforcement. According to the National Crime Victimization Study, it is estimated that for every sexual assault that is reported to the police, there are an additional 6 sexual assaults that go unreported. Additionally, it is estimated that 1 out of 4 women in America will be sexually assaulted in her lifetime. For more information on sexual violence prevention, go to www.vahealth.org/civp/sexualviolence.

Prevent Suicide Virginia
The Center for Injury and Violence Prevention coordinates the Virginia Department of Health's efforts as lead agency for Virginia's Youth Suicide Prevention Plan. For more information, go to www.preventsuicideve.org, or call Calvin Nunnally to schedule a training at 804-864-7736. Call 1-800-SUICIDE for help and to get help for someone you know.

Domestic Violence Prevention
Domestic violence is a public health issue that transcends gender, ethnic, racial and socioeconomic boundaries. It is estimated that 30 percent of all women are abused in their lifetime. About 40 percent of female victims of violence reported being injured. Abused women have higher levels of health care use yet only a small percentage of female patients have reported being asked about abuse by health care professionals or disclosing abuse to them. Health care providers can play a vital role in preventing domestic violence by screening women for intimate partner violence, counseling and referring them to appropriate resources.

Resources:

- Virginia Hotline for Family Violence and Sexual Assault - 1-800-838-8238, for professionals to help clients, and to help people in crisis
- Continuing medical education - www.dvcme.org, a domestic violence education course developed by the American Medical Women's Association. Course designed for physicians, residents, medical students, and other health care professionals.
- Preventing Domestic Violence: Clinical Guidelines on Routine Screening - endabuse.org/programs/healthcare/files/screpol.pdg, this is the first national, multi-specialty, comprehensive routine screening documents on domestic violence.

- American College of Obstetricians and Gynecologists - http://acog.org/from_home/department/category.cfm?recono=17&bulletin+176, a screening tool for health care professionals.
- RADAR: A Domestic Violence Interview - www.opdv.state.ny.us/health_humsvc/health/radar.html

Contact: Erima Shields-Fobbs, Director, 804-864-7733, erima.fobbs@vdh.virginia.gov, website www.vahealth.org/civp/domesticviolence.

Childhood Injury Prevention

Child Passenger Safety - The Four Steps of Child Passenger Safety
Growing children should progress through three types of child safety seats before using the seat belt alone:

1. Rear-facing infant seat: Infants should ride in a rear-facing seat from birth until they are at least 1 year old and weigh at least 20 pounds. Remember, never place a rear-facing seat in a front seat with a passenger air bag.
2. Forward-facing child safety seat: Children from age 1 to about age 4 and weighing 20 to 40 pounds should be properly restrained in a forward-facing child safety seat.
3. Booster Seat: After they outgrow the forward-facing safety seat, graduate children to a booster seat. They should remain in a booster seat from about age 4 until they are at least age 8 and under 4 feet, 9 inches tall.
4. Seat Belts: Children who are at least 8 years old or over 4 feet, 9 inches tall should wear a seat belt on every ride. Children under age 12 should ride in the rear of the vehicle.

The Child Safety Seat Program is a statewide child safety seat distribution and education program offered to indigent families. Over 8,000 seats are provided each year with funding from the Child Restraint Special Device Fund and are distributed through local health districts. Ongoing regular training, assistance and refresher courses are provided to local staff to enable them to educate safety seat recipients about correct installation and use of child safety seats. To qualify for a free child safety seat, applicants must be:

- Medicaid eligible
- Legal residents of Virginia
- Parent, legal guardian, or foster parent of the child
- At the earliest, in the last trimester of pregnancy
- Preference is given to applicants with children under the age of one
- Recipients must attend a safety seat installation and use class
- Must sign a waiver of liability release form

For more information concerning the program or for other technical assistance on child occupant protection and resource information, contact 1-800-732-8333, or contact your local health department.

Home Safety

Many childhood injuries happen in the home. Room-by-room checklist is available at www.vahealth.org/civp/childinjury/home_safety.htm.

Education resources are available by contacting Shannon Wright at 1-800-732-8333.

Car Seat Safety

One-Day Event - Child Passenger Safety Seat Checks - www.safetyseat.va.org gives the locations for car seat safety checks.

Other Resources:

- Virginia's Child Restraint Device Law (Code of Virginia Article 13 - Section 46.2)
- Virginia's Passenger Safety Belt Law (Code of Virginia Article 12 - Section 46.2)
- Virginia's Pickup Truck Law (Code of Virginia Section 46.2 - 1094)
- National Highway Traffic Safety Administration - http://www.nhtsa.dot
- Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents - www.brightfutures.org

Contact: Marcia Franchok-Hill, Statewide Safety Seat Program Coordinator, 804-864-7737, Marcia.Franchok-Hill@vdh.virginia.gov, website http://www.safetyseatva.org/index.htm.

SECTION 8
Other State or Local Resources and Programs

The Virginia Chlamydia Prevention Program
Screening Criteria

- Females under 35 visiting STD clinics who are receiving a pelvic examination
- Females under 30 in family planning clinics who are receiving a pelvic examination
- All prenatal clinic patients
- Male partners of infected females

For more information on the Virginia Chlamydia Prevention Program, please contact the Chlamydia Program Coordinator at (804) 864-7954.

The Virginia Perinatal Hepatitis B Prevention (VPHBP) Program
The Virginia Perinatal Hepatitis B Prevention Program is a collaborative effort with local health departments and private providers to identify hepatitis B surface antigen (HBsAg) positive pregnant women and their household contacts and sexual partners. Once identified, free testing and vaccine, if needed, is provided to the contacts and partners of these women. Free Hepatitis B Immune Globin (HBIG) and hepatitis B (HB) vaccine for newborns of infected mothers are provided to the delivery hospital and the infant's physician to prevent the spread of HBV from mother to newborn. VDH Division of Immunization, 800-568-1929, website www.vdh.state.va.us/imm/index.htm.

Healthy Families
Healthy Families is a family support program providing new parent information and referral services. The program works in partnership with the local birthing hospital, as well as intensive home-based prevention services for families with children from birth to five years of age. The program offers services designed to:

- strengthen families
- improve maternal and child health outcomes
- promote optimal child development
- increase positive parenting knowledge and behavior
- prevent child abuse and neglect and other negative parenting and childhood outcomes

Healthy Families targets overburdened families in the most historically high-risk communities. Home visiting services are offered to new parents who have been identified through a standardized screening and assessment process. Families are accepted into the program prenatally or at the time of delivery. If a family accepts the offer of voluntary home visitation, home visits are provided at least twice a month prior to the birth of the baby and weekly after the baby's birth to provide support and education services. Visits decrease in frequency as the family becomes more knowledgeable and independent. Families may receive these home-visiting services until the child enters kindergarten.

Contact: Amy Strite, Vice President of Early Childhood and Family Development, 804-282-4255, 804-285-3701 Fax, Family Lifeline, 1518 Willow Lawn Drive, Richmond, VA 23230, website www.family-lifeline.org.

Comprehensive Health Investment Project (CHIP of VA)
CHIP of VA programs are local public/private partnerships, which provide comprehensive care coordination. CHIP provides family support and referral to medical and dental services for low-income at-risk children. CHIP programs provide a case management process which helps identified families connect to needed services. The program does not directly provide medical or dental services. Local programs are overseen by both a management team and an advisory council. The management team includes executive or senior level management of partner agencies, e.g., public health and community-based organizations. The advisory group is a broad group comprised of community representatives from local government, social services, health, mental health, education, private business, and parents.

Contact: Sandy Graves, 804-233-2850.

Community Service Boards (CSBs)
Statewide the Department of Mental Health, Mental Retardation and Substance Abuse Services is organized into 40 CSBs offer varying combinations of six core services:

1. emergency services
2. local inpatient services
3. outpatient and case management services
4. day support services
5. residential services
6. prevention and early intervention services

CSBs exist to provide individual, flexible, effective, integrated and efficient services in the most accessible, responsive and appropriate yet least restrictive settings possible. They draw upon all available community resources along with people's natural support systems (family, friends, work) to ameliorate the effects of mental disabilities and substance abuse, encourage growth and development, and assist individuals to realize their maximum potentials. CSBs also enable individuals with mental disabilities or substance abuse problems to access services in state mental health and mental retardation facilities through pre-admission screening, case management, and client services management. Sections 37.1-197, 197.1 and 198 of the Code of Virginia specify the legal duties and responsibilities of board members and the CSBs which they direct. Martha Kurgans, Department of Mental Health, Mental Retardation & Substance Abuse Services, (804) 371-2184, mkurgans@dmhmrsas.state.va.us.

Richmond City Healthy Start
The Richmond Healthy Start Initiative works to eliminate disparity in perinatal and post partum healthcare for minority women and infants. This program unites several

community-based agencies to make prenatal medical support services and parenting education accessible to women and teens who are pregnant or parents of infants.

- Two programs, CHIP of Greater Richmond and Healthy Families Richmond/East District Families First Program, offer home visits, parenting education and case management services to improve the health and well being of pregnant women and teens. Eligible women can receive transportation to medical and social service appointments.
- Middle school students in City schools receive education on postponing sexual involvement through the Virginia League for Planned Parenthood.
- Women who have substance abuse problems and are pregnant or have just given birth are provided with outpatient treatment and support services from the Richmond Behavioral Health Authority.
- If a family experiences the death of an infant, the Central Commonwealth Perinatal Council FIMR program provides counseling sessions to help the family through the grieving process.

Richmond Healthy Start is committed to women, infants, parents and families to ensure that every baby is given a healthy start. Contact: Rose Stith-Singleton, Program Manager/Family and Child Health, 804-646-3335.

Table 1
Prenatal Laboratory Evaluations

TABLE 1: PRENATAL LABORATORY EVALUATIONS

TYPE & TEST	PURPOSE	WHO TO TEST	WHEN TO TEST	RESULTS/COMMENTS
Blood type/ Atypical Antibody Screen	Assess for specific blood type and potential for Rh incompatibility	All pregnant women	Initial visit and repeat as indicated	If Rh incompatibility identified, patient will require Rh immune globulin at around 28 weeks or before if potential blood mixing procedure is done, i.e., amniocentesis
Hgb/Hct (CBC optional)	Detect anemia	All pregnant women	Initial visit & at least 1x in 2nd and 3rd trimester	Determination of anemia
SAFP/Triple Screen	Assess the risk of neural tube defects and Down syndrome	All pregnant women	16--18 weeks (ACOG)	Indication of possible NTDs or Down Syndrome. For positive results further testing required. **Informed consent or refusal of testing should be documented in pts. record.**
Hepatitis B Virus Surface Antigen (HbsAG)	Assess for hepatitis B infection	All pregnant women who have not been immunized or whose status is unknown	Initial visit (ACOG)	Women who test negative should be offered vaccination during pregnancy. A series of 3 scheduled injections required
Serologic test for syphilis	Assess for syphilis infection	All pregnant women	Initial visit and at beginning of 3rd trimester	Appropriate treatment for stage of infection at diagnosis. Infants are at risk of congenital syphilis. (Test at initial visit and at delivery, ACOG)
Rubella	Assess for immunity to rubella	All pregnant women without previously documented positive immunity	Initial visit	Seronegative women should be immunized immediately postpartum, **not recommended during pregnancy due to teratogenic risk to the fetus (ACOG). Avoid conception for 1 month after rubella vaccination.**
Sickle Cell (hemoglobin electrophoresis)	Test for sickle cell disease and trait.	Optional based on ethnic background and family history	Initial visit	Assist in patient identification during pregnancy or helps parents prepare for infant with defects
1Hr plasma glucola test	Test assesses for the development of gestational diabetes	All pregnant women	Test between 26-28 weeks (ACOG)	If 1 hr is abnormal, refer for 3 hr GTT (Glucose Tolerance Test), may refer to clinician. (Appendix J)
Human Immunodeficiency Virus (HIV)	Assesses for the presence of the HIV virus	Offered to all pregnant women	Initial visit and at third trimester, if indicated. 15-20 weeks, ideally between 16-18 weeks (ACOG)	Evaluate for treatment to prevent perinatal transmission. Informed consent/refusal for testing documented in patient's record.
Urinalysis/C&S	Assess for abnormal protein, glucose, and asymptomatic bacteria	All pregnant women	Initial visit and at intervals during pregnancy	Identification of infections of the urinary tract, both symptomatic and non-symptomatic
Urine Dipstick	Screening tool to identify constituents in the urine	All pregnant women	Initial visit and every subsequent visit	Screen for sugar and protein in urine. Positive results require further evaluation.

TYPE & TEST	PURPOSE	WHO TO TEST	WHEN TO TEST	RESULTS/COMMENTS
Chlamydia	Assess for chlamydia	All pregnant women	Initial visit and repeated in 3rd trimester if initial test was positive	Positive status indication for treatment
Gonorrhea	Assess for gonorrhea	All pregnant women	Initial visit & 3rd trimester	Identification of gonorrhea infection
Group Beta Streptococci (GBS)	Assess for GBS	All pregnant women, at 37 weeks (32-36, ACOG)	During third trimester	Positive results require prophylaxis during the intrapartum period with antibiotic treatment to prevent an infant with GBS. Chart should be flagged and patient counseling done.
Papanicolaou smear	Assess for abnormal cervical cells	All pregnant women unless documentation of **testing within the last 6 months, at the discretion of clinician**	Initial visit (ACOG)	Identification of abnormal cervical cells that may require treatment. **Follow the American Society for Colposcopy and Cervical Pathology algorithms.** (Appendix G)
Cystic Fibrosis	Carrier status	All pregnant women informed. Screening offered to all couples.	Preconception 1st and early 2nd trimester	Positive results require counseling concerning risk to the fetus. (Appendix K)

Revised June 2004